

Item 7, Film G231, 7/10/58
CERTIFICATE OF DEATH
 Reg. Dist. No. 07453

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. STATE <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles E. Biddell</u>				4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Biddell</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Lucille Biddell</u> Address <u>Berlin MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443 X</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO <u>4 yrs</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>54</u> , to <u>6/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/21</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin, Md</u>		DATE SIGNED <u>6/23/58</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr.</u>				<u>Berlin, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>6-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Decker M. Lewis</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Decker M. Lewis</u>	

Constitution

19

7442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Norchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>	
c. LENGTH OF STAY IN 1b <u>4 years</u>		d. STREET ADDRESS <u>R 2 Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Carmean</u> Middle Last		4. DATE OF DEATH <u>June 1</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17 1891</u> 6/7/2/17
9. AGE (In years last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner Manager of Pharmacy</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willard Carmean</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Parsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give year or date of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>200-26-209</u>	
17. INFORMANT <u>Mrs Charlotte S. Carmean, Berlin, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 26</u> , 19 <u>58</u> , to <u>June 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>58</u> , and that death occurred at <u>2301</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ocean City, Md</u> DATE SIGNED <u>June 2, 58</u>			
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>F. J. Townsend, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Phila. Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harmon V. Harris</u> ADDRESS <u>Snover Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>W. H. Search</u> DATE <u>JUN 3 '58</u>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 may be retained by the hospital or attending physician. TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Manner of Death		Occupation	
Physician's Signature		Medical Examiner's Signature		Registrar's Signature	
Date of Death		Time of Death		Place of Death	
Hospital or Institution		City		County	
State		Zip Code		Registration District	
Registrar's Office		City		County	
State		Zip Code		Registration District	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>Pocomoke, Md</u>	
3. NAME OF DECEASED (Type or print) <u>BABY BOY COOKS</u>		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>Willie Cook</u>		14. MOTHER'S MAIDEN NAME <u>Beulah Nixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Willie Cook - Pocomoke, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> p. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>R.B. Wharton Memorial Park, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		24. REC'D BY REGISTRAR <u>W. H. Hedrick</u>	
ADDRESS		DATE <u>JUN 19 1958</u>	

5049254 XVV

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Decem-ber
Name
Baby Boy
Decem-ber
Name
Decem-ber
Name

No
Willie Cook
Infant
Maryland
1.2.11
Willie Cook
Nixon
Willie Cook

Filed for Record - 1000000000
Filed for Record - 1000000000

7443

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>503 A Dighton Street</u>				d. STREET ADDRESS <u>503 A Dighton Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charlie</u> <u>Butler</u> <u>Dix</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-3-1904</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Peterlizer Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charlie Dix</u>				14. MOTHER'S MAIDEN NAME <u>Mannie ? Dix</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-22-8706</u>		17. INFORMANT <u>Mrs. Audery Dix, 503 A Dighton St. Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>441X</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>24 hrs</u> <u>6 mos</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1-24</u> , 19 <u>58</u> , to <u>6-27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-27</u> , 19 <u>58</u> , and that death occurred at <u>1:45P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>Berlin, Md</u>		DATE SIGNED <u>6/30/58</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully Jr. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Wesley Cemetery</u>		22d. LOCATION (City, town, or county) <u>Mt Wesley, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md</u>				ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Al. Lewis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7444

CERTIFICATE OF DEATH

07437

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>				c. LENGTH OF STAY IN 1b <u>1 WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 3V01-4</u>			
				d. STREET ADDRESS <u>701 N. CHAPEL GATE LANE</u>			
3. NAME OF DECEASED (Type or print) First <u>LILY</u> Middle <u>MAY</u> Last <u>DORSEY</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 27, 1975</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>JOHN BRATTEN</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA AMANDA STANDEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mrs E. D. BROHAWN</u> Address <u>BALTO, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2.4 hrs.</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>17 June, 1958</u> , to <u>18 June, 1958</u> , that I last saw the deceased alive on <u>17 June, 1958</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. J. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>Phila at north, Ocean City, Md.</u>			
PHYSICIAN'S NAME (Type) <u>N. D. Thomas</u>				DATE SIGNED <u>18 June 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOWDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ann A. B... Berlin Md</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

7445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin - Rural</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>305 S. Camp Meade Road</u>	
3. NAME OF DECEASED (Type or print) <u>George Cleveland Grate</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1889</u> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Cleveland Grate</u>		14. MOTHER'S MAIDEN NAME <u>IDA FISHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-6779</u>	
17. INFORMANT <u>MRS. G. C. GRATE</u>		Address <u>LINTHICUM HEIGHTS, 305 S. CAMP MEADE RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary disease</u> <u>Instant</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Too much activity comparing & fishing</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. F. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <u>N. F. Sartorius</u>	
EXAMINER'S NAME (Type) <u>N. F. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENN HAVEN C</u>	22d. LOCATION (City, town, or county) (State) <u>GLENN BURNIE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. Singleton</u>		ADDRESS <u>Glenn Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. H. Leach</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	
DATE <u>JUN 18 58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



7446

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Philadelphia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HILDA BELLE HALL</u>		4. DATE OF DEATH Month Day Year <u>JUNE 28 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1917</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RFD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY A. BRADFORD</u>		14. MOTHER'S MAIDEN NAME <u>LOTTIE JACKSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-16-7184</u>	
17. INFORMANT Address <u>MR. ELMER HALL OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> <u>142X</u> DUE TO <u>Hypertensive cardiovascular remodeling 1 year.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 19, 57</u> to <u>June 28, 1958</u> , that I last saw the deceased alive on <u>June 27, 1958</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Ocean City, Md</u>		DATE SIGNED <u>June 30, 58</u>	
PHYSICIAN'S NAME (Type) <u>F. TOWNSEND, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboze</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '58</u>	
ADDRESS <u>Berlin Md</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7447

CERTIFICATE OF DEATH

Reg. Dist. No. 07440

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Herring Creek</u>	
3. NAME OF DECEASED (Type or print) First <u>HIRAM</u> Middle <u>EDWARD</u> Last <u>HARRIS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1880</u>
9. AGE (In years [last birthday]) <u>78</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHIEF ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>WILMINGTON DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL P. HARRIS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA WOODWARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>070-14-9964</u>	
17. INFORMANT Address <u>Mrs. Elsie Harris Berlin Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>post cerebral hemorrhage</u> DUE TO <u>atherosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>right hemiparesis and diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>3-4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>58</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Grubb Md.</u>		ADDRESS (Street, city or town, state) <u>BERLIN, MD</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>		DATE SIGNED <u>6/30/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>JULY 1, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SILVERBROOK</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>WILMINGTON DEL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '58</u>	
ADDRESS <u>Anna A. Burbage Berlin Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7448

CERTIFICATE OF DEATH

Reg. Dist. No.

07441

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MD b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE EDWARD HASTINGS				4. DATE OF DEATH Month Day Year JUNE 21 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 1, 1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MAJOR HASTINGS				14. MOTHER'S MAIDEN NAME CATHERINE GRAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 2-17-36-2461		17. INFORMANT Address MRS. ROLAND CAREY JR. BERLIN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, sec 4 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Disease (c) Senile arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 40 min 48 1130	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) markedly emphysematous						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 8 , 19 57 , to June 21 , 19 58 , that I last saw the deceased alive on June 21 , 19 58 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Anna A. Burbo M.D.				ADDRESS (Street, city or town, state) Berlin, Md		DATE SIGNED 6/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 6/24/58		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) BERLIN MD			
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbo ADDRESS Berlin Md.				24a. REC'D BY REGISTRAR DATE JUN 25 '58		24b. REGISTRAR'S SIGNATURE Rebecca	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

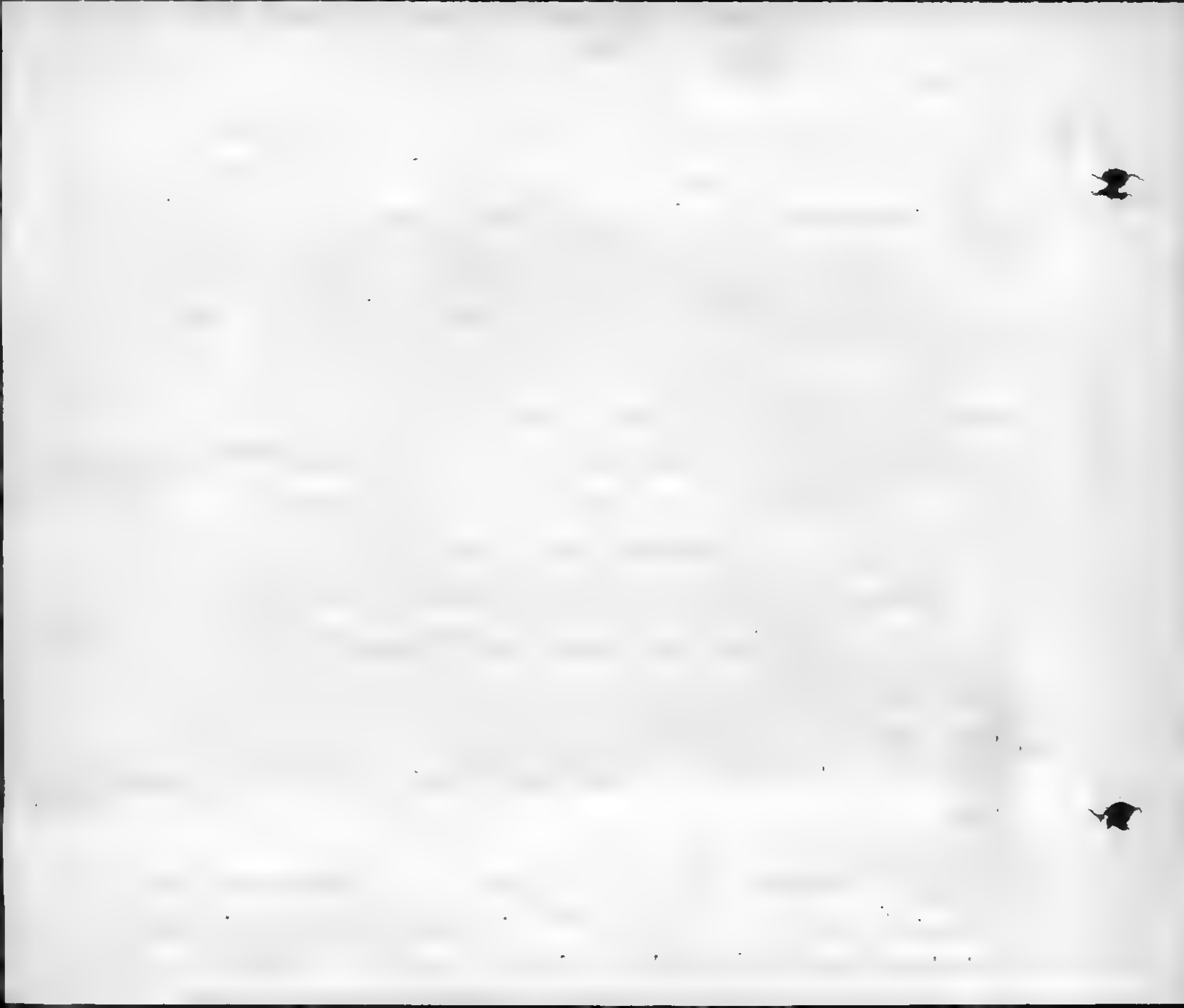
7449

CERTIFICATE OF DEATH

07442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worcester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hilton Hotel</u>		d. STREET ADDRESS <u>4401 Underwood St</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Lloyd Hayleek</u>		4. DATE OF DEATH <u>June 22</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hayleek</u>		14. MOTHER'S MAIDEN NAME <u>Ella Crouch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dr. Mary Hayleek</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c)).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion Acute</u> <u>4.0.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>A-S-EVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nausea Vomiting & Diarrhea preceded attack</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 21, 1958</u> , to <u>June 22, 1958</u> , that I last saw the deceased alive on <u>June 21, 1958</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Ocean City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>F. J. Townsend, Jr.</u>		DATE SIGNED <u>June 23 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Tickner & Sons</u>		ADDRESS <u>Balto. 17, Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7450

CERTIFICATE OF DEATH

Reg. Dist. No.

07443

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXX				d. STREET ADDRESS Rural			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HORACE First H. Middle HICKLAN Last				4. DATE OF DEATH June 14 Month 1958 Day 19 Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1891	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 6 Days 26 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hickman				14. MOTHER'S MAIDEN NAME Ella Rodgers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) XX		16. SOCIAL SECURITY NO. 220-09-2862		17. INFORMANT Laura Hickman Address Bishopville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Deg. Myocarditis & Anomalous							2 yrs
DUE TO (b) Rheumatic Myocarditis &							2 yrs
DUE TO (c) Chronic Deforming Arteritis multiple							8 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pernyphous Bullosa chron. Recurrent 6 mos.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 14, 1958 , to June 14, 1958 , that I last saw the deceased alive on June 14, 1958 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Berlin, Md.				DATE SIGNED 6/14/58			
ACTUAL SIGNATURE Harman A. Robbins, M.D.							
PHYSICIAN'S NAME (Type) Harman A. Robbins, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/58		22c. NAME OF CEMETERY OR CREMATORY TOOE		22d. LOCATION (City, town, or county) (State) Bishopville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley, Baltimore, Md.				24a. REC'D BY REGISTRAR DATE JUN 18 1958		24b. REGISTRAR'S SIGNATURE Carl Smith	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7451
CERTIFICATE OF DEATH

07444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Jackson</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15 - 1895</u>
9. AGE (In years last birthday) <u>63 3/4 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomac Virginia</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Daniel Wise</u>		14. MOTHER'S MAIDEN NAME <u>Leona Sneed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. George Jackson</u>		Address <u>Snow Hill, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cerebral Vascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Congestive Cardiac failure & Coloma</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1955</u> to <u>June 26, 1958</u> , that I last saw the deceased alive on <u>June 26, 1958</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. LaMar</u>		ADDRESS (Street, city or town, state) <u>104 Bury St</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. LAMAR</u>		DATE SIGNED <u>6/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coolidge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Smith</u>		ADDRESS <u>Snow Hill, MD</u>	
24a. REC'D BY REGISTRAR <u>JUN 30 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7452

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) b. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS WASHINGTON	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MAUDE ESTHER JARVIS		4. DATE OF DEATH Month Day Year JUNE 9 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18, 1888
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NEWARK MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERA BOWGIN		14. MOTHER'S MAIDEN NAME SAVANNAH AYDELOTTE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO NO	
17. INFORMANT MR. HARRY L JARVIS, BERLIN MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma, ascending colon & sigmoid DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) metastasis - ascites DUE TO (c) Cachexia			INTERVAL BETWEEN ONSET AND DEATH 8 7 mo 3 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 25 Dec , 1957, to 9 June , 1958, that I last saw the deceased alive on 9 June , 1958, and that death occurred at 2:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Harmon L. Adams M.D.		DATE SIGNED 11 June 58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/11/58	22c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S	22d. LOCATION (City, town, or county) (State) BERLIN MD.
23. FUNERAL DIRECTOR'S SIGNATURE Anna D. Burbage Berlin Md.		24a. REC'D BY REGISTRAR JUN 12 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE Willie...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7453

CERTIFICATE OF DEATH

Reg. Dist. No. 117441

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RUFUS THAMES JONES				4. DATE OF DEATH Month JUNE Day 18 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 26, 1956	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Month 5 Days 5 Hours 5 Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SALISBURY MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOSEPH LEE JONES			
14. MOTHER'S MAIDEN NAME MARGARET G. CARR.				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. —				17. INFORMANT Address MRS. J. L. JONES BERLIN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 757.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Internal abnormality DUE TO (c) Hydrocephalus + Kidney						INTERVAL BETWEEN ONSET AND DEATH From birth From birth From birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6-18 , 19 58 , to 6-18 , 19 58 , that I last saw the deceased alive on Never , 19 — , and that death occurred at 2-15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin Md. DATE SIGNED Clifford E. Schott							
ACTUAL SIGNATURE Clifford E. Schott M.D.							
PHYSICIAN'S NAME (Type) Clifford E. Schott M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6/21/58		TAYLORVILLE		BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burboye				ADDRESS Berlin Md		24a. REC'D BY REGISTRAR DATE JUN 23 '58	
				24b. REGISTRAR'S SIGNATURE Alberich			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7454

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Amie Lafferty Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle Last MASON		4. DATE OF DEATH Month June Day 13 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1862
9. AGE (In years last birthday) 95 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. ---		16. SOCIAL SECURITY NO. None	
17. INFORMANT Worcester County		Address W67 St. 3 door's	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brights DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 13, 1958, to Jan 13, 1958, that I last saw the deceased alive on Jan 12, 1958, and that death occurred at 8 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas R. Law M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Burlin Md 6-14-1958	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 6-18-58	22c. NAME OF CEMETERY OR CREMATORY Beth Eden Cemetery	22d. LOCATION (City, town, or county) (State) Rural Pocomoke City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke, Md.	24a. REC'D BY REGISTRAR DATE JUN 19 '58
		24b. REGISTRAR'S SIGNATURE W. H. Seuch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

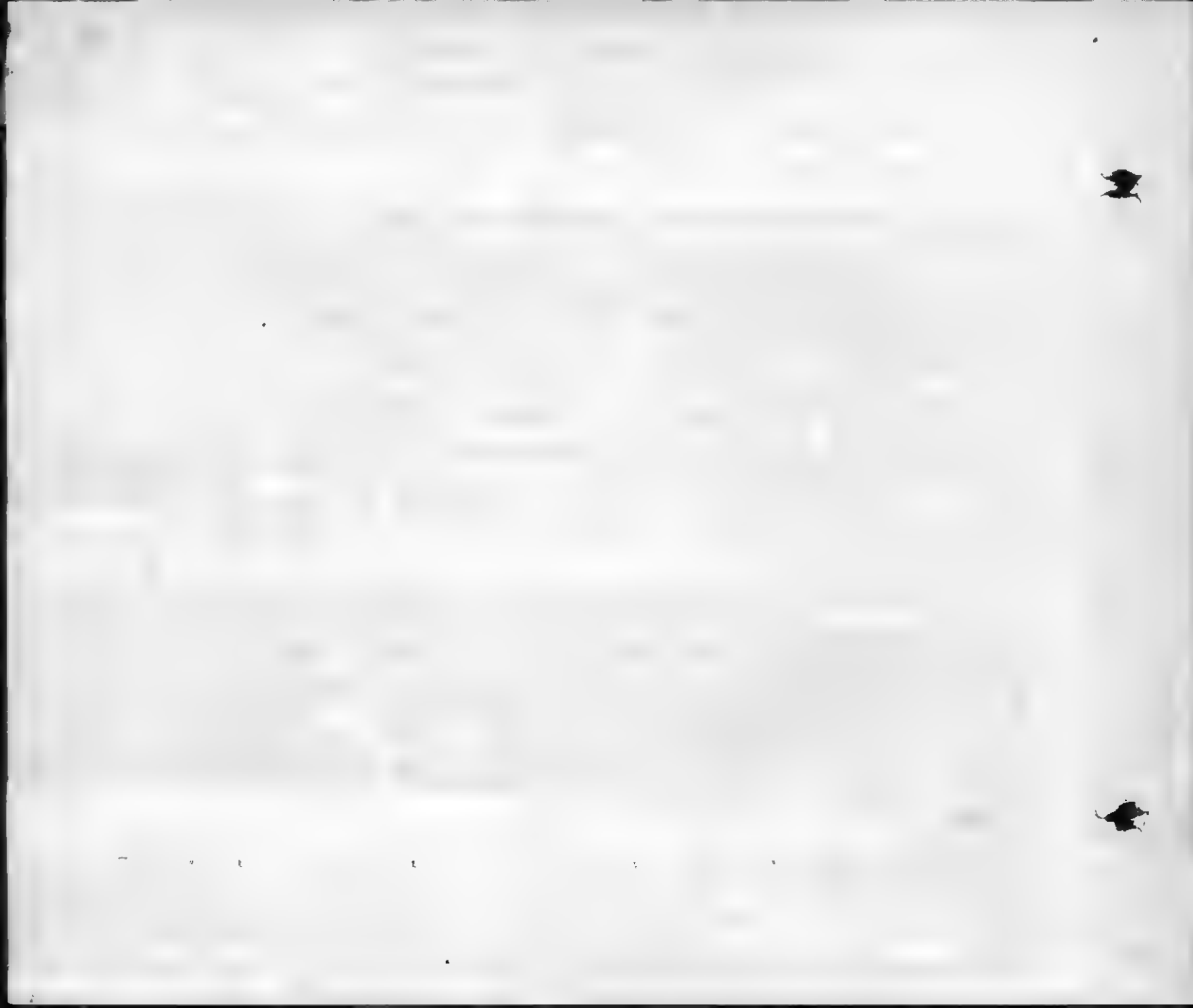
7439

CERTIFICATE OF DEATH

Reg. Dist. No.

07448

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1511 North Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Larry B. Moser</u>				4. DATE OF DEATH Month Day Year <u>June 10 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1866</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Poterfield</u>		14. MOTHER'S MAIDEN NAME <u>Susan Doughty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>W. F. Moser, Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Disease</u> DUE TO (c) <u>Chronic Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-7-58</u> , 19 <u>58</u> , to <u>6-10-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-10-58</u> , 19 <u>58</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Charles W. Trader, M.D.</u>							
ACTUAL SIGNATURE <u>Charles W. Trader</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Charles W. Trader, MD, 302 Market Street, Pocomoke City, Md. 6-11-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Latist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u>				ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. F. Moser</u>							



CERTIFICATE OF DEATH

07449

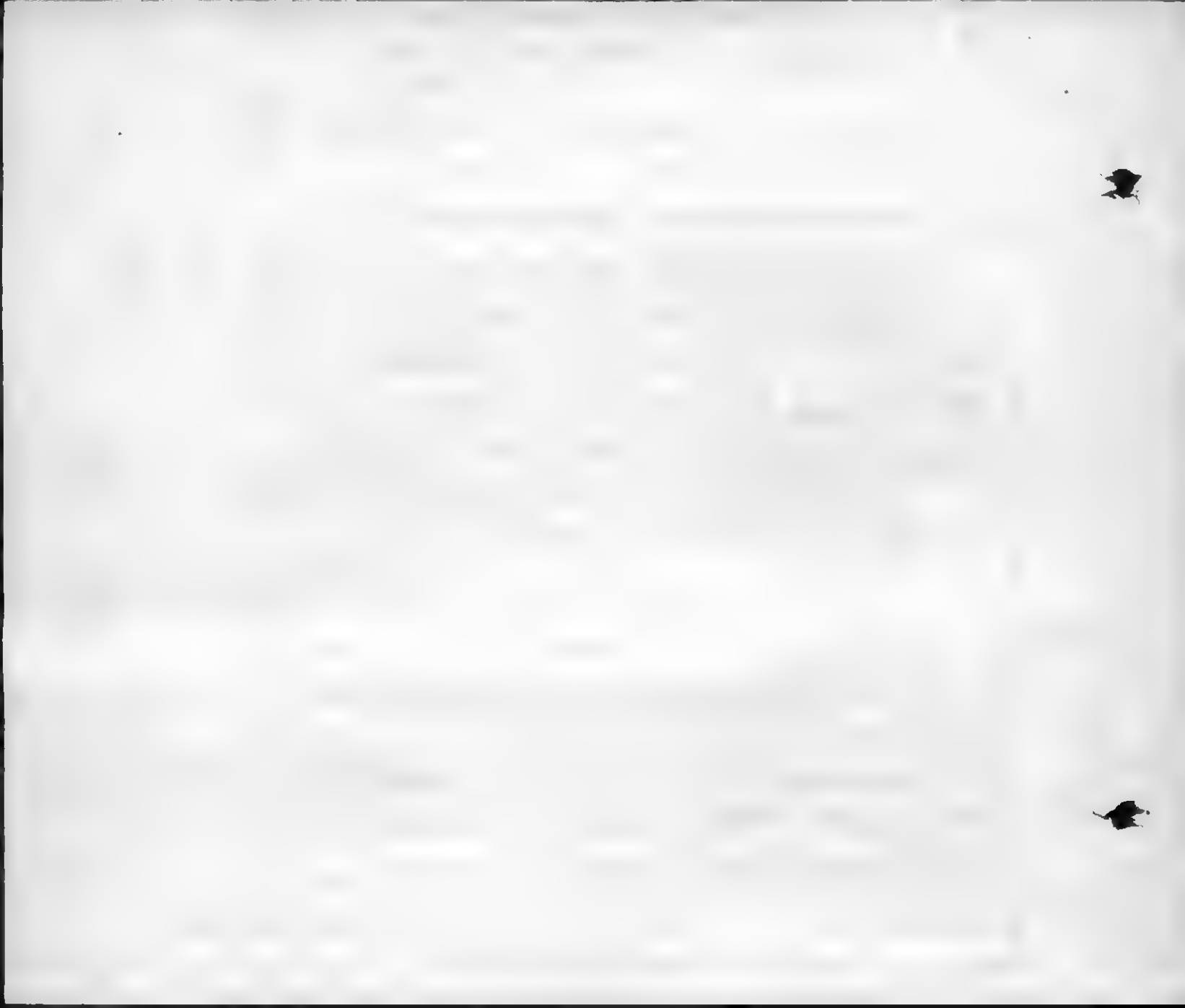
Reg. Dist. No.

7455

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALTON</u> <u>—</u> <u>OUTTEN</u>		4. DATE OF DEATH Month Day Year <u>June</u> <u>28</u> <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>	11. BIRTHPLACE (State or foreign country) <u>Pocomoke Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		13. FATHER'S NAME <u>Julius C. Outten</u>	
14. MOTHER'S MAIDEN NAME <u>Mary A. Slocumb</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-32-0517</u>		17. INFORMANT <u>Mervin B. Outten</u> Address <u>1 Norfolk Virginia</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>(Arteriosclerosis)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 years</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 28, 1958</u> , to <u>June 28, 1958</u> , that I last saw the deceased alive on <u>June 28, 1958</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. E. Critcher</u> M.D.		ADDRESS (Street, city or town, state) <u>Worcester Md.</u> DATE SIGNED <u>June 28, 1958</u>	
PHYSICIAN'S NAME (Type) <u>C. E. CRITCHER, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 1, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Pocomoke Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry B. Watson</u> ADDRESS <u>Pocomoke Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 2 '58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>W. S. Leach</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07450

Reg. Dist. No.

7456

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Market St</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Chester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>316 East 9th</u> d. STREET ADDRESS <u>316 East 9th</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ronald</u> Middle <u>Alvin</u> Last <u>Profitt</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13-1932</u>
9. AGE (In years last birthday) <u>25 21/2</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Sinwood, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Profitt</u>		14. MOTHER'S MAIDEN NAME <u>Martha Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Dorothy Profitt</u>		Address <u>316 East 9th St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull with profuse hemorrhage</u> DUE TO (b) <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 to 5 minute</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Trying to elude arrest</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Thrown from car while driving over 100 miles per hour</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>6/28/58</u> Hour <u>4:05</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Snow Hill, Worcester, Pa</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. E. Santorus Sr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Santorus MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/28/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>July 3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chester, Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Summers</u>		ADDRESS <u>Snow Hill, Md</u>	
24. REC'D BY REGISTRAR <u>Alb. Smith</u>		DATE <u>JUL 1 '58</u>	
25. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 4 and 5 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 4th Street		e. STREET ADDRESS 1 205 4th Street	
3. NAME OF DECEASED (Type or print) First Arthur Middle C. Last Richards		4. DATE OF DEATH Month June Day 24 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wesley Richards		14. MOTHER'S MAIDEN NAME Ester Cantwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Lula B. Richards, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Disease; atherosclerosis DUE TO (c) Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1958 to June 24, 1958 , that I last saw the deceased alive on June 24, 1958 , and that death occurred at 6:54 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Trader M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 302 Market, Pocomoke City, Md. 6-25-58	
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-58	
22c. NAME OF CEMETERY OR CREMATORIUM Bethany Methodist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson		ADDRESS Pocomoke, Md.	
24a. REC'D BY REGISTRAR JUN 30 58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7457

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b 65 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE POWELL WARREN		4. DATE OF DEATH Month Day Year JUNE 17 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 20 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLIE POWELL		14. MOTHER'S MAIDEN NAME ELIZABETH TRUITT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MR. HARRY J. WARREN		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertension DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 10 1958 to June 17 1958 that I last saw the deceased alive on June 17 1958 and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas R. Saw M.D.		ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED 6-18-58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/19/58	22c. NAME OF CEMETERY OR CREMATORY EVERGREEN	22d. LOCATION (City, town, or county) (State) BERLIN MD
23. FUNERAL DIRECTOR'S SIGNATURE Amos A. Burbage ADDRESS Berlin Md		24a. REC'D BY REGISTRAR DATE JUN 20 '58	24b. REGISTRAR'S SIGNATURE Overman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907

FILE NO.

Blank lines for handwritten entry of death certificate information.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS